

This form may be completed online, printed and mailed to the address listed below.

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATION AND LICENSURE
CREDENTIALING DIVISION
P. O. BOX 94986
LINCOLN, NE 68509-4986
(800) 422-3460 / (402) 471-2158
APPLICATION FOR APPROVAL AS AN
EMERGENCY MEDICAL SERVICES TRAINING AGENCY

SECTION A

Please Print

APPLICANT INFORMATION

Level of Approval Requested:

Basic _____ Advanced _____ (Check appropriate level)

Name of the Training Agency: _____

Mailing Address: _____

City/State/Zip: _____

Name of the Contact Person: _____

Telephone Number: _____

Name of the Medical Director: _____ License # _____

Mailing Address: _____

City/State/Zip: _____

Telephone Number: _____

SECTION B

REQUIRED ATTACHMENTS TO THIS APPLICATION

1. A copy of your training agency's catalogue as prescribed in 172 NAC 13-003.01 item 12.
2. A copy of your written agreement with the physician medical director who has agreed to serve as your Training Agency Medical Director.
3. A copy of your written agreement with the hospital(s), clinic(s), and/or physician offices(s) that will provide clinical training.
4. A copy of your written agreement with the licensed emergency medical service(s) that will provide field internships when applicable.
5. List of the names of the primary instructor(s) and their level of certification/licensure.
6. Surety bond in the penal sum of \$20,000.
7. A list of person(s) or entities that have 25% or more financial interest of ownership

SECTION C

(All applicants must answer the following questions)

Have you provided training of EMS courses as an EMS Training Agency prior to the date of this application? Yes _____ No _____

If yes, how many days have you provided training. _____
No. of Days

SECTION D

VERIFICATION OF MEETING REGULATION STANDARDS

By our signatures below, we certify that the above named Emergency Medical Services Training Agency meets the standards defined in Sections 13-003 and 13-004 of Title 172 NAC Chapter 13, Regulations Governing Emergency Medical Services Training Agencies and will teach the EMS Courses as defined in Subsection 13-002 of the regulations, and in accordance with the guidelines set forth in the curricula. (Signatures must be originals)

Head of Training Agency

Medical Director

Print _____

Print _____

Signature _____

Signature _____

Date _____

Date _____

SECTION E

FOR USE BY THE BOARD OF EMERGENCY MEDICAL SERVICES INSPECTION VERIFICATION

Inspected by: _____

Inspection results: Pass Fail

Date: _____

Approved by the Board: Yes No

Date: _____